

1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS BOQ 4707, Room 216		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last ADLER				4. DATE OF DEATH Month November Day 3 Year 1958			
5. SEX Male		6. COLOR OR RACE CAU.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH. Jan. 22, 1911	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nashville, Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George A. Adler				14. MOTHER'S MAIDEN NAME Mary Watts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. See reverse side 408-01-7861		17. INFORMANT Official U.S. Army Records, Ft Geo. G. Meade, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 976x DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Gun shot wound, head, with 30-30 calibre rifle				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ? Nov. 3 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BOQ 4707, Room 216		20f. (City or town) (County) (State) Ft George G. Meade, A.A. Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Harry F. Sproat</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Lt. Col. Harry F. Sproat, M.C.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4 November 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-5-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Nashville, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hars</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

No. 15-Military Service, U.S. Army, as follows:

5 Mar. 42-21 Nov.45; 18 Sep. 46-2 Oct.51; 3 Oct 51-date of death.

Acting Deputy Medical Examiner,
State of Maryland:

Harry F. Sproat
Harry F. Sproat, Lt. Col., MC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12050

CERTIFICATE OF DEATH

12025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co. Md.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville Md.</i>		c. LENGTH OF STAY IN 1b <i>1 mo - 15 da</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore - 12. Md. 3401-4</i>		d. STREET ADDRESS <i>527 Fenbridge Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dennis Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ELIJAH Cookman - BAKER</i>		4. DATE OF DEATH Month Day Year <i>11 - 17 19 58</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-16-1873</i>
9. AGE (In years lost birthday) yrs. <i>85</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Minister.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS - P. BAKER</i>		14. MOTHER'S MAIDEN NAME <i>Wood (LIDA.)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-6089</i>	
17. INFORMANT <i>Mary - V. Sann.</i> Address <i>Cecil - Rd, Millersville - Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>151X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma stomach inoperable</i> DUE TO <i>1 year</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardio Vascular Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>11 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-6-58</i> to <i>11-17-58</i> , that I last saw the deceased alive on <i>11-16-58</i> and that death occurred at <i>9A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		ADDRESS (Street, city or town, state) <i>Odenton Md</i> DATE SIGNED <i>11-17-58</i>	
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKEY</i>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-20-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Orem's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Stemmers Run, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		ADDRESS <i>1217 St. Paul Street</i>	
24a. REC'D BY REGISTRAR <i>NOV 19 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12051

CERTIFICATE OF DEATH

12027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2m 26d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 603 N. Paca Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Sherman		Middle Clark		Last Boone	
4. DATE OF DEATH		Month 11		Day 5		Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/39		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Boone				14. MOTHER'S MAIDEN NAME Ethel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Huntington's Chorea						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 8/9, 19 58, to 11/5, 19 58, that I last saw the deceased alive on 11/5, 19 58, and that death occurred at 9:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Reissman		M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		DATE SIGNED 11/6/58	
PHYSICIAN'S NAME (Type) Hildegard Reissman, M. D.				Crownsville State Hospital, Md.		11/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-58		22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead				ADDRESS 918 Druid Hill Ave		24a. REC'D BY REGISTRAR DATE NOV 10 58	
						24b. REGISTRAR'S SIGNATURE Wilbur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12052

CERTIFICATE OF DEATH

12028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum			c. LENGTH OF STAY IN 1b 11 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linthicum			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #305 S. Camp Meade Rd.				d. STREET ADDRESS #305 S. Camp Meade Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JOSE BOWERS				4. DATE OF DEATH Month Day Year November 12, 19 58				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1874.		
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. Huskey				14. MOTHER'S MAIDEN NAME Susin Ogle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mae W. Grahe		Address Same As #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 4 1/2 -		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 19 42 to 11/12 , 19 58 , that I last saw the deceased alive on 11/12/58 , 19 58 , and that death occurred at 4:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/12/58								
ACTUAL SIGNATURE Chas. L. Ball				M.D. Linthicum				
PHYSICIAN'S NAME (Type) R V Singleton								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14/58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE R V Singleton				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE NOV 18 '58		
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF BURIAL	
16. NAME OF BURIAL PLACE		17. NAME OF MINISTER		18. NAME OF CHURCH	
19. NAME OF FUNERAL HOME		20. NAME OF CEMETERY		21. NAME OF INTERMENT	
22. NAME OF INTERMENT		23. NAME OF INTERMENT		24. NAME OF INTERMENT	
25. NAME OF INTERMENT		26. NAME OF INTERMENT		27. NAME OF INTERMENT	
28. NAME OF INTERMENT		29. NAME OF INTERMENT		30. NAME OF INTERMENT	
31. NAME OF INTERMENT		32. NAME OF INTERMENT		33. NAME OF INTERMENT	
34. NAME OF INTERMENT		35. NAME OF INTERMENT		36. NAME OF INTERMENT	
37. NAME OF INTERMENT		38. NAME OF INTERMENT		39. NAME OF INTERMENT	
40. NAME OF INTERMENT		41. NAME OF INTERMENT		42. NAME OF INTERMENT	
43. NAME OF INTERMENT		44. NAME OF INTERMENT		45. NAME OF INTERMENT	
46. NAME OF INTERMENT		47. NAME OF INTERMENT		48. NAME OF INTERMENT	
49. NAME OF INTERMENT		50. NAME OF INTERMENT		51. NAME OF INTERMENT	
52. NAME OF INTERMENT		53. NAME OF INTERMENT		54. NAME OF INTERMENT	
55. NAME OF INTERMENT		56. NAME OF INTERMENT		57. NAME OF INTERMENT	
58. NAME OF INTERMENT		59. NAME OF INTERMENT		60. NAME OF INTERMENT	
61. NAME OF INTERMENT		62. NAME OF INTERMENT		63. NAME OF INTERMENT	
64. NAME OF INTERMENT		65. NAME OF INTERMENT		66. NAME OF INTERMENT	
67. NAME OF INTERMENT		68. NAME OF INTERMENT		69. NAME OF INTERMENT	
70. NAME OF INTERMENT		71. NAME OF INTERMENT		72. NAME OF INTERMENT	
73. NAME OF INTERMENT		74. NAME OF INTERMENT		75. NAME OF INTERMENT	
76. NAME OF INTERMENT		77. NAME OF INTERMENT		78. NAME OF INTERMENT	
79. NAME OF INTERMENT		80. NAME OF INTERMENT		81. NAME OF INTERMENT	
82. NAME OF INTERMENT		83. NAME OF INTERMENT		84. NAME OF INTERMENT	
85. NAME OF INTERMENT		86. NAME OF INTERMENT		87. NAME OF INTERMENT	
88. NAME OF INTERMENT		89. NAME OF INTERMENT		90. NAME OF INTERMENT	
91. NAME OF INTERMENT		92. NAME OF INTERMENT		93. NAME OF INTERMENT	
94. NAME OF INTERMENT		95. NAME OF INTERMENT		96. NAME OF INTERMENT	
97. NAME OF INTERMENT		98. NAME OF INTERMENT		99. NAME OF INTERMENT	
100. NAME OF INTERMENT		101. NAME OF INTERMENT		102. NAME OF INTERMENT	

MADE IN U.S.A. 100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Pages 4 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12028

CERTIFICATE OF DEATH

12029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel Crownsville MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 1521 N. Gilmore Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Julia Judy Coe Bowler				4. DATE OF DEATH Month Day Year 11 7 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years lost birthday) 75? yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Coe				14. MOTHER'S MAIDEN NAME Charity Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Record Address Crownsville, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with left hemiplegia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease with old myocardial infarct DUE TO (c) Dehydration and Malnutrition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration and Malnutrition INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1956 , to 11-7- 19 58 , that I last saw the deceased alive on 11-7-58 19 and that death occurred at 8:00p.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 11-8-58							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				Crownsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/58		22c. NAME OF CEMETERY OR CREMATORY Mt Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Marbare P. Hays ADDRESS 638 N. Gilmore St				24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

13082

Judy Coe

1941/11/21 The Lutheran Church
St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12053

CERTIFICATE OF DEATH

Reg. Dist. No.

12030

1. PLACE OF DEATH a. COUNTY <u>A. A. Co Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort Meade Hosp</u>		d. STREET ADDRESS <u>Severn md</u>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Brewell</u> First Middle Last		4. DATE OF DEATH <u>11-25</u> Month Day Year <u>1958</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. E.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Monroe Bell</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Remover Wade</u> Address <u>1935 Walbrook ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>54</u> , to <u>November 24</u> , 19 <u>58</u> , that I lost s/he the deceased alive on <u>November 24</u> , 19 <u>58</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emerson R. Julian</u> M.D.		ADDRESS (Street, city or town, state) <u>1207 Madison Ave</u> DATE SIGNED <u>11/25/58</u>	
PHYSICIAN'S NAME (Type) <u>EMERSON R. JULIAN, M.D.</u>		<u>BALTIMORE MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. B. Kelton</u> ADDRESS <u>13487. Calhoun st</u>		24a. REC'D BY REGISTRAR DATE <u>11/26/58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Khan</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12031

12029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Crownsville</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY in 1b <u>4yrs., 6mo., 19days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				d. STREET ADDRESS <u>1347 Stockton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Eriscow</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 15, 1881</u>			
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>4</u>		IF UNDER 24 HRS. <u>77</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>					
17. INFORMANT <u>Hospital Record</u>				Address <u>Crownsville, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and Malnutrition</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis and Senility</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the Prostate with Pulmonary metastases.</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Baltimore</u>				(County) <u>Baltimore</u>		(State) <u>Maryland</u>			
21. I certify that I attended the deceased from <u>July</u> <u>1956</u> , to <u>11-8-</u> <u>1958</u> , that I last saw the deceased alive on <u>11-8-</u> <u>1958</u> , and that death occurred at <u>6:15 a.m.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>					
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				DATE SIGNED <u>11-8-58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) <u>Bald.</u> (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Holston</u>				ADDRESS <u>918 Druid H. 11A</u>		24a. REC'D BY REGISTRAR <u>11-8-58</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>									

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12054

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seyern</u>			c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3001-4</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Queenstown Road.</u>				d. STREET ADDRESS <u>1818 Mount St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Albert Carpenter</u>				4. DATE OF DEATH Month Day Year <u>November 25th</u> <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>9/6/85</u>		9. AGE (in years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>Adrena Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[illegible]</u>		17. INFORMANT <u>Mary E. Carpenter</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay W. Wilson</u>				ADDRESS <u>1800 [illegible]</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. [illegible]</u>			

MEDICAL CERTIFICATION

13038

MARYLAND STATE DEPARTMENT OF HEALTH - ANNAPOLIS 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Witness		14. Signature of Physician		15. Signature of Funeral Home	
16. Signature of Undertaker		17. Signature of Cemetery		18. Signature of Burial	
19. Signature of Interment		20. Signature of Burial		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
37. Signature of Burial		38. Signature of Burial		39. Signature of Burial	
40. Signature of Burial		41. Signature of Burial		42. Signature of Burial	
43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial	
52. Signature of Burial		53. Signature of Burial		54. Signature of Burial	
55. Signature of Burial		56. Signature of Burial		57. Signature of Burial	
58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial	
64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
67. Signature of Burial		68. Signature of Burial		69. Signature of Burial	
70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
79. Signature of Burial		80. Signature of Burial		81. Signature of Burial	
82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
85. Signature of Burial		86. Signature of Burial		87. Signature of Burial	
88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12033

Item 18 Film 237 12-31-58 am

12055

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ft Meade Hosp.</u>		d. STREET ADDRESS <u>Kerger Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Theodore</u> Last <u>Deweese</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 April 58</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Theodore Dewees</u>		14. MOTHER'S MAIDEN NAME <u>Betty Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Betty Dewees</u>		Address <u>Mother: Ellicott City, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric lymphadenitis, severe.</u> <u>527.2</u> DUE TO <u>Aspiration of stomach contents into larynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Respiratory obstruction due to occlusion of trachea & larynx by vomitus</u> DUE TO (c) <u>Unknown cause</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DOA 23 Nov</u> , 19 <u>58</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u>1340P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>23 Nov 58</u> ACTUAL SIGNATURE <u>John F. Plant</u> M.D. <u>U.S. Army Hospital, Ft Meade, Md</u> PHYSICIAN'S NAME (Type) <u>JOHN F PLANT, Capt, MC</u> <u>U.S. Army Hospital Ft Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J C Sigurdson</u>		ADDRESS <u>Ellicott City Md</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Frank</u>	

9VVVVVVXVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12034

12030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Vesley</u> Middle <u>Dorman</u> Last			4. DATE OF DEATH <u>Nov.</u> Month <u>28</u> Day <u>19</u> Year <u>58</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 11 1911</u>			
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allen McCormick Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Allen McCormick Co.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Warren Dorman</u>				14. MOTHER'S MAIDEN NAME <u>Wood Tull</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Barnet Dorman</u> Address <u>Annapolis</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Pleurisy and</u> <u>518 X</u> DUE TO <u>Pericarditis with Rupture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysematous bleb and collapse of Rt. Lung.</u> DUE TO (c) <u>Emphysematous bleb and collapse of Rt. Lung.</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>May 15, 1958</u> to <u>11/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>M.D. 110-CLAY ST ANNAPOLIS</u> DATE SIGNED <u>12/1/58</u>					
PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salsbury</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12056

CERTIFICATE OF DEATH

12035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie,</u>			c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#407 Joyce Drive, S.W.</u>				d. STREET ADDRESS <u>#407 Joyce Drive, S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HART</u> Middle <u>N.</u> Last <u>DOUGLASS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Civil Ser.</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Douglass</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Dorothy Douglass</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>420.1</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 55</u> , to <u>Nov. 6, 19 58</u> , that I last saw the deceased alive on <u>October 27, 19 58</u> , and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>11/6/58</u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> <u>Glen Burnie, Md.</u> <u>11/6/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stafford Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Batavia, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1901

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		M		35		JAN 1 1866		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
NEW YORK		LABORER		HEART DISEASE		NATURAL		NEW YORK	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 1 1901		10 00 AM		10 00		00		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
NEW YORK		LABORER		HEART DISEASE		NATURAL		NEW YORK	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 1 1901		10 00 AM		10 00		00		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
NEW YORK		LABORER		HEART DISEASE		NATURAL		NEW YORK	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12031 Items 11.14 Film G236 11-21-58 et
CERTIFICATE OF DEATH

12036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>		d. STREET ADDRESS <u>Rt. 9, Box 468-A</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MYRON First Middle Last</u> <u>ENGEL JAY ENGEL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-57</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>20</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES ENGEL</u>		14. MOTHER'S MAIDEN NAME <u>Marie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FATHER</u>		Address <u>Rt. 9, Box 468-A</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Menigitis, H. Influenza</u> DUE TO (c) <u>4 wks.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PASADENA, MD</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>58</u> , to <u>11-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-16</u> , 19 <u>58</u> , and that death occurred at <u>3:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D.			
PHYSICIAN'S NAME (Type) <u>CLAYTON NORTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kunkley</u> ADDRESS <u>Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12080

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12121

Reg. Dist. No.

1. PLACE OF DEATH		2. NAME OF DECEASED	
HOME		JOHN J. SMITH	
3. SEX		4. RACE	
MALE		WHITE	
5. AGE		6. DATE OF BIRTH	
45		JAN 15 1900	
7. MARRIAGE		8. PLACE OF BIRTH	
MARRIED		BALTIMORE, MD	
9. OCCUPATION		10. CAUSE OF DEATH	
CLOCK MAKER		HEART DISEASE	
11. DATE OF DEATH		12. TIME OF DEATH	
JAN 20 1945		10:30 AM	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY	
CATHOLIC CHURCH		MOUNT RAINIER	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF CLERIC	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12057

CERTIFICATE OF DEATH

12037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3m 11d</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1630 Hopewell</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Epps</u> Last <u>Epps</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Epps</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Epps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u>9</u> m. <u>15</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/22</u> , 19 <u>58</u> , to <u>11/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>4:55A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>		DATE SIGNED <u>11/3/58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				Crownsville State Hospital, Md. <u>11/3/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Balto. 25, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home - 1631 Druid Hill Ave</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12032

CERTIFICATE OF DEATH

12038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Dora</u> Last <u>FAIRMAN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Derrick NIEHBUR</u>		14. MOTHER'S MAIDEN NAME <u>Schalind LELAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 November, 1958</u> , to <u>25 November, 1958</u> , that I last saw the deceased alive on <u>25 November, 1958</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Richard S. Hochman</u> M.D.		U.S. Naval Hospital <u>25 November 1958</u>	
PHYSICIAN'S NAME (Type) <u>R. HOCHMAN LT MC USNR</u>		<u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 10088		CERTIFICATE OF DEATH 10088	
1. NAME OF DECEASED [Name]		2. SEX [Sex]	
3. DATE OF BIRTH [Date]		4. PLACE OF BIRTH [Place]	
5. DATE OF DEATH [Date]		6. PLACE OF DEATH [Place]	
7. TIME OF DEATH [Time]		8. CAUSE OF DEATH [Cause]	
9. DISEASE OR INJURY [Disease]		10. MANNER OF DEATH [Manner]	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	
13. SIGNATURE OF WITNESS [Signature]		14. SIGNATURE OF WITNESS [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
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21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]	
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67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]	
71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]	
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77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]	
81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]	
83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]	
87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF WITNESS [Signature]	
89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]	
95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]	
99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12058

CERTIFICATE OF DEATH

12039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY ANN ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA P.O.		c. LENGTH OF STAY IN 1b 5 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA P.O.	
3. NAME OF DECEASED (Type or print) LOLA VIRGINIA GODSEY First Middle Last		d. STREET ADDRESS Box 240 BAR HARBOR RD	
4. DATE OF DEATH Nov 26 1958 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 25 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE BENSON		14. MOTHER'S MAIDEN NAME MARY VIRGINIA GAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS HARRY DAVIS Address AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac decompensation 260 X DUE TO Arteriosclerotic Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus, mild DUE TO (c) Hepatic insufficiency of several years duration		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic insufficiency of several years duration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1, 1958 to November 26, 1958 , that I last saw the deceased alive on November 25, 1958 , and that death occurred at 12:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Box 442 Pasadena, Md. DATE SIGNED Nov 26, 1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF Nov 27 1958	
22c. NAME OF CEMETERY OR CREMATORY GWYNNS		22d. LOCATION (City, town, or county) (State) MATHEWS VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Jukew & Sons No. 2 Ave. ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12059

CERTIFICATE OF DEATH

12040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Jessup Road		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Charlotte May Grace		4. DATE OF DEATH Month November Day 17 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland, Jessup		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles L. Dixon		14. MOTHER'S MAIDEN NAME Margaret Coulson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT B.L. Gardner, Jessup Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno-Carcinoma of cecum DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 57 , to November 17 , 19 58 , that I last saw the deceased alive on November 17 , 19 58 , and that death occurred at 87.35A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 80A Hanover Md, November 18, 1958 DATE SIGNED			
ACTUAL SIGNATURE E. Roderick Shipley		PHYSICIAN'S NAME (Type) E. Roderick Shipley M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Harvey Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur E. Frank		ADDRESS Nov 24 '58	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

10846-10847

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12033

CERTIFICATE OF DEATH

12042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamburles Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad. General Hosp</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Hamilton</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1881</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Queen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edith Queen Hamburles Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-17-58</u> , 19 <u>58</u> , to <u>11-21-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-21-58</u> , 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>612 Cathedral St</u>		DATE SIGNED <u>11-21-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt. Sabor</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. (Luna) Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>James S. Travis</u>	

THE 1900-2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12060

CERTIFICATE OF DEATH

12043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville - Md.</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sann's Nursing Home</u>		d. STREET ADDRESS <u>1130 Conduit St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> - B- Middle <u>Hyde</u> Last <u>Hyde</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890 July 4 - 1899</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary V. Sann</u> Address <u>Cecil Rd. Millersville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma Left Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 3-58</u> to <u>Nov 1-58</u> , that I last saw the deceased alive on <u>Oct 29, 1958</u> , and that death occurred at <u>7:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Adelphi Md</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKY</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne S Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>Nov 5 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

CERTIFICATE OF DEATH

13063

Page One

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>1945-10-15</i>		5. TIME OF DEATH <i>10:00 AM</i>	
6. PLACE OF DEATH <i>Home</i>		7. CITY <i>Baltimore</i>		8. COUNTY <i>Harford</i>		9. STATE <i>Md.</i>		10. ZIP CODE <i>21030</i>	
11. OCCUPATION <i>Teacher</i>		12. CAUSE OF DEATH <i>Heart Disease</i>		13. MANNER OF DEATH <i>Natural</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		15. SIGNATURE OF REGISTRAR <i>John Doe</i>	
16. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

13063

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12061 CERTIFICATE OF DEATH

12045

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A-A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arundel Beach Rd.</u>				1 d. STREET ADDRESS <u>Arundel Beach Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Wheeler Jenkins</u>				4. DATE OF DEATH Month Day Year <u>November 17 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 10, 1873</u>		9. AGE (In years last birthday) yrs. <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas W Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>TERESA RACHEL Mary X. Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Spanish Am. war</u>				16. SOCIAL SECURITY NO. <u>213-10-7689</u>		17. INFORMANT <u>Mrs Pribyl - (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Failure</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis C.V. Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19, to <u>1958</u> , 19, that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 20 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins</u>				ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hahn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12034

CERTIFICATE OF DEATH

12044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Chesapeake</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Chesapeake md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>1 Annapolis md</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennings</u>		4. DATE OF DEATH Month Day Year <u>November 3 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1958</u>
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Curtis Edward Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Beverly Ann Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address <u>Bertram Circle, Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis fetalis (severe)</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>58</u> , to <u>11/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>58</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Amos J. Jones</u> <u>11/13/58</u>			
ACTUAL SIGNATURE <u>S. B. Dr. S. S. Clark</u>		M.D. <u>Amos J. Jones</u>	
PHYSICIAN'S NAME (Type) <u>S. B. Dr. S. S. Clark</u>		<u>Annapolis md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 4-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Ch Co md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blond G. Fink</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 5 58</u>	
ADDRESS <u>Glen Burnie md</u>		24b. REGISTRAR'S SIGNATURE <u>James A. Smith</u>	

2063224XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12062 CERTIFICATE OF DEATH

12047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach, Edgewater</u>		c. LENGTH OF STAY IN 1b <u>5 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Shore Drive, Woodland Beach</u>	
3. NAME OF DECEASED (Type or print) <u>Ida</u> First Middle <u>Kernekin</u> Last		4. DATE OF DEATH <u>Nov. 28</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1865</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		12. CITIZEN OF WHAT COUNTRY? <u>Permanent resident of U.S. A.</u>	
13. FATHER'S NAME <u>Anton Gerling</u>		14. MOTHER'S MAIDEN NAME <u>G. Grossbernd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John E. Kernekin</u> Address <u>Edgewater, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive cardiac failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> 184 years (c) <u>184 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 24, 1958</u> to <u>Nov. 27, 1958</u> , that I last saw the deceased alive on <u>Nov. 28, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD #1 Box 277-14, 11-28-58</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>		DATE SIGNED <u>Edgewater, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12063

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Harundale)</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>505 Westway Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred Christian Kippel</u> First Middle Last				4. DATE OF DEATH <u>Nov. 25-1958</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/94</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher at the Metal Shop, High School.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. Paul, Nebraska.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Kippel (Kippel)</u> <u>William Kippel</u>				14. MOTHER'S MAIDEN NAME <u>Annie Lahautz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>First World War. Army.</u>		16. SOCIAL SECURITY NO. <u>291-22-4097</u>		17. INFORMANT Address <u>Mrs. Evelyn Kippel (wife)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harold National</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd Baltimore Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Fink</u>				ADDRESS <u>Bellevue</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fink</u>			

MEDICAL CERTIFICATION

1200X

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1900

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12051

12066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>102 Bay ave</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park md</u>				d. STREET ADDRESS <u>102 Bay ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Ellicott Maccoun</u>				4. DATE OF DEATH Month Day Year <u>Nov. 30 1958</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Coast Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Admiral Robert Toxland Maccoun</u>				14. MOTHER'S MAIDEN NAME <u>Harvey Bond Ellicott</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Coast Guard</u>		16. SOCIAL SECURITY NO. <u>422.1</u>		17. INFORMANT <u>Daughter Mrs. A. Mylander</u>		Address <u>Arnold, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen Arteriosclerosis</u> DUE TO (c) <u>Gen Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19____, to <u>11-30-58</u> , 19____, that I last saw the deceased alive on <u>11-29-58</u> , 19____, and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Robert R. Hahn</u>				ADDRESS (Street, city or town, state) <u>Severna Park md</u>				DATE SIGNED <u>11-30-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				<u>Severna Park md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Huntingdon</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins</u>				ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>	

CERTIFICATE OF DEATH

MARY ANN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page One of One

<p>1. Name of deceased: <u>MARY ANN</u></p>	
<p>2. Date of birth: <u>1911</u></p>	
<p>3. Date of death: <u>1961</u></p>	
<p>4. Place of birth: <u>MD</u></p>	
<p>5. Place of death: <u>MD</u></p>	
<p>6. Cause of death: <u>HEART DISEASE</u></p>	
<p>7. Duration of illness: <u>10</u></p>	
<p>8. Name of physician: <u>DR. J. H. SMITH</u></p>	
<p>9. Name of funeral home: <u>JOHN SMITH</u></p>	
<p>10. Name of next of kin: <u>JOHN SMITH</u></p>	
<p>11. Name of informant: <u>JOHN SMITH</u></p>	
<p>12. Name of registrar: <u>JOHN SMITH</u></p>	
<p>13. Name of registrar: <u>JOHN SMITH</u></p>	
<p>14. Name of registrar: <u>JOHN SMITH</u></p>	
<p>15. Name of registrar: <u>JOHN SMITH</u></p>	
<p>16. Name of registrar: <u>JOHN SMITH</u></p>	
<p>17. Name of registrar: <u>JOHN SMITH</u></p>	
<p>18. Name of registrar: <u>JOHN SMITH</u></p>	
<p>19. Name of registrar: <u>JOHN SMITH</u></p>	
<p>20. Name of registrar: <u>JOHN SMITH</u></p>	
<p>21. Name of registrar: <u>JOHN SMITH</u></p>	
<p>22. Name of registrar: <u>JOHN SMITH</u></p>	
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<p>29. Name of registrar: <u>JOHN SMITH</u></p>	
<p>30. Name of registrar: <u>JOHN SMITH</u></p>	
<p>31. Name of registrar: <u>JOHN SMITH</u></p>	
<p>32. Name of registrar: <u>JOHN SMITH</u></p>	
<p>33. Name of registrar: <u>JOHN SMITH</u></p>	
<p>34. Name of registrar: <u>JOHN SMITH</u></p>	
<p>35. Name of registrar: <u>JOHN SMITH</u></p>	
<p>36. Name of registrar: <u>JOHN SMITH</u></p>	
<p>37. Name of registrar: <u>JOHN SMITH</u></p>	
<p>38. Name of registrar: <u>JOHN SMITH</u></p>	
<p>39. Name of registrar: <u>JOHN SMITH</u></p>	
<p>40. Name of registrar: <u>JOHN SMITH</u></p>	
<p>41. Name of registrar: <u>JOHN SMITH</u></p>	
<p>42. Name of registrar: <u>JOHN SMITH</u></p>	
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<p>83. Name of registrar: <u>JOHN SMITH</u></p>	
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<p>93. Name of registrar: <u>JOHN SMITH</u></p>	
<p>94. Name of registrar: <u>JOHN SMITH</u></p>	
<p>95. Name of registrar: <u>JOHN SMITH</u></p>	
<p>96. Name of registrar: <u>JOHN SMITH</u></p>	
<p>97. Name of registrar: <u>JOHN SMITH</u></p>	
<p>98. Name of registrar: <u>JOHN SMITH</u></p>	
<p>99. Name of registrar: <u>JOHN SMITH</u></p>	
<p>100. Name of registrar: <u>JOHN SMITH</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12067

CERTIFICATE OF DEATH

12052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x LINTHICUM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Box #1025 ANDOVER RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGIANNA MAHONEY</u>		4. DATE OF DEATH Month Day Year <u>11 29 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM RILEY</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT GRIFFIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MYRTLE HOWARD LINTHICUM MD</u>	
17. INFORMANT <u>MYRTLE HOWARD LINTHICUM MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 CARDIO VASCULAR DISEASE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 1952, to <u>11/29</u> , 1958, that I last saw the deceased alive on <u>11/29</u> , 1958, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. <u>LINTHICUM</u> <u>11/30/58</u> PHYSICIAN'S NAME (Type) <u>CHARLES L. BALL JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes 6382 GILMORE ST</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frawls</u>			

12005

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12005

DATE OF DEATH

PLACE OF DEATH

HUSBAND

LIST OF OTHER PERSONS PRESENT AT THE TIME OF DEATH

LIST OF OTHER PERSONS PRESENT AT THE TIME OF DEATH

LIST OF OTHER PERSONS PRESENT AT THE TIME OF DEATH

LIST OF OTHER PERSONS PRESENT AT THE TIME OF DEATH

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LIST OF OTHER PERSONS PRESENT AT THE TIME OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12068

CERTIFICATE OF DEATH

12053

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lanar Nursing Home</u>		d. STREET ADDRESS <u>14 Seven Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>VIRGINIA</u> Last <u>MAGRUDER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Helena, Montana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ferris</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary Jean Williams</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobar Pneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Rheumatoid Arthritis</u> DUE TO (c) <u>Cerebral Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490 Hemiplegia - Peroneal</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>11-9-58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-9-58</u> to <u>11-14-58</u> , that I last saw the deceased alive on <u>11-13-58</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Odenton Md</u>	
DATE SIGNED <u>11-14-58</u>			
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>PRICE GEORGE Co. Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
DATE <u>NOV 19 58</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

15002

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

<p>1. NAME OF DECEASED <i>JOHN J. BROWN</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910</i></p>	
<p>5. PLACE OF BIRTH <i>NEW YORK</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. NAME OF SPOUSE <i>MARY J. BROWN</i></p>		<p>10. DATE OF DEATH <i>1955</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>16. DATE OF REGISTRATION <i>1955</i></p>	

12064

CERTIFICATE OF DEATH

Reg. Dist. No.

12049

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> Maryland b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>1y 1m 1d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>22-12-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>204 Pollit Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Bell</u> Last <u>McBride</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Care</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. McBride</u>				14. MOTHER'S MAIDEN NAME <u>Sallie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia and Septicemia</u> <u>443X</u> DUE TO <u>Intertrochanteric Fractured Left Hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> <u>493X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>factory, street, office, etc.</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>10/29</u> , 19 <u>57</u> , to <u>11/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>58</u> , and that death occurred at <u>9:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>12/1/58</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital</u> <u>12/1/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Anatomy Board Bldg</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Reese</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12065

CERTIFICATE OF DEATH

12050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Riviera Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hall & Kenwood Rds.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>D.</u> Middle <u>McCLELLAN</u> Last		4. DATE OF DEATH <u>NOV</u> Month <u>4</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supplies Wholesale Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Samuel C. McClellan</u>		14. MOTHER'S MAIDEN NAME <u>Alice P. White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Eleanor M. Yeatman - Hall & Kenwood Rd.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA COLON</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTASES TO LIVER</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>1 MONTH</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>SEPT. 1958</u> to <u>NOV. 4, 1958</u> , that I last saw the deceased alive on <u>NOV. 3, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		DATE SIGNED <u>11/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto 17 Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

13830

10

MARYLAND STATE DEPARTMENT OF HEALTH
Baltimore, Md.
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Baltimore, Md.		Heart disease		Natural		John Doe, M.D.		John Doe, Registrar	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of report		18. Signature of informant		19. Signature of registrar		20. Signature of physician	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		Jan 16, 1965		Jane Doe		John Doe, Registrar		John Doe, M.D.	

FOND

DE 11-11-65

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12035

CERTIFICATE OF DEATH

12055

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 McKendree Ave				d. STREET ADDRESS 214 McKendree Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle Wilson Last Mervine				4. DATE OF DEATH Month November Day 16 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19, 1878		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Tilghman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward N. Lomax				14. MOTHER'S MAIDEN NAME Frances A. Hussey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Victor E. Harrison, Wittman, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular Disease DUE TO (c) Arteriosclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yrs. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 1, 19 58 , to Nov. 16, 19 58 , that I last saw the deceased alive on Nov. 15, 19 58 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw St. Annapolis, Md. DATE SIGNED Nov. 16, 1958							
ACTUAL SIGNATURE James R. Martin M.D.				DATE SIGNED Nov. 16, 1958			
PHYSICIAN'S NAME (Type) James R. Martin				ADDRESS 6 Shaw St. Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		11-18-58		Sherwood Cemetery		Sherwood Md	
23. FUNERAL DIRECTOR'S SIGNATURE S. Hankerton Harrison, St. Michael				24. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12036

CERTIFICATE OF DEATH

12056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Birdsville	
		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle H Last MORELAND		4. DATE OF DEATH Month NOVEMBER Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Prop.		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Calbert Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD MORELAND		14. MOTHER'S MAIDEN NAME MARY E. CROSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-16-1782	
17. INFORMANT Mrs. Lillie A. Moreland- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 23, 1958 , to Nov 23, 1958 , that I last saw the deceased alive on Nov 23, 1958 , and that death occurred at 8 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED 11/24/58 ACTUAL SIGNATURE Elmer G. Linhardt M.D. Elmer G. Linhardt PHYSICIAN'S NAME (Type) Elmer G. Linhardt MD Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-58	
22c. NAME OF CEMETERY OR CREMATORY Edwards Chapel		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12037

Item 3 Film G236 12-12-58 et

CERTIFICATE OF DEATH

12054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>MARROW</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 November 1958</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George MARROW</u>		14. MOTHER'S MAIDEN NAME <u>Lily May HOLLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		

21. I certify that I attended the deceased from 5 November, 1958, to 5 November, 1958, that I last saw the deceased alive on 5 November, 1958, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE F. M. KENNY LT MC USNR

PHYSICIAN'S NAME (Type) F. M. KENNY LT MC USNR U.S. Naval Hospital, Annapolis, Md. 11-6-58

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-8-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carpenter Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Round Bay Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #1087 Wash. St. Annap. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

CERTIFICATE OF DEATH

1937

NAME OF DECEASED		DATE OF BIRTH		SEX		MARRIAGE		EDUCATION		OCCUPATION		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		RACE		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		JAN 15 1895		M		MARRIED		HIGH SCHOOL		LABORER		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		METHODIST		ARMY		JAN 25 1937		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE OF BIRTH		MOTHER'S STATE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S RACE		MOTHER'S RACE		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
JAMES H. HARRIS		JANE H. HARRIS		LABORER		HOUSEWIFE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		WHITE		METHODIST		METHODIST		ARMY		ARMY		JAN 25 1937		JAN 25 1937	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		RACE		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		RACE		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH	
JAN 25 1937		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		METHODIST		ARMY		JAN 25 1937		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		METHODIST		ARMY		JAN 25 1937		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE OF BIRTH		MOTHER'S STATE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S RACE		MOTHER'S RACE		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
JAMES H. HARRIS		JANE H. HARRIS		LABORER		HOUSEWIFE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		WHITE		METHODIST		METHODIST		ARMY		ARMY		JAN 25 1937		JAN 25 1937	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		RACE		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		RACE		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH	
JAN 25 1937		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		METHODIST		ARMY		JAN 25 1937		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		WHITE		METHODIST		ARMY		JAN 25 1937		BALTIMORE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12057

12069

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanese</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>First Aid Room - Lanese Race Track</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lanese</u> Middle <u>Carl</u> Last <u>Murkey</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/7/95</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shedder Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Murkey</u>				14. MOTHER'S MAIDEN NAME <u>Louise Schmitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1917</u>				16. SOCIAL SECURITY NO. <u>215-03290</u>		17. INFORMANT Address <u>Mrs. Ursula M. Lohrey</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> <u>p. m.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				DATE SIGNED <u>11/3/58</u>			
EXAMINER'S NAME (Type) <u>GUSTAVE-H. FAUBERT, M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Buried Nov 6 58 Oak Lawn</u>		22b. DATE THEREOF <u>Nov 6 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Deenmann</u> ADDRESS <u>6067 Hay Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of medical examiner	
9. Signature of physician		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of registrar	
17. Signature of health officer		18. Signature of police		19. Signature of fire department		20. Signature of other officials	
21. Signature of family		22. Signature of neighbors		23. Signature of community		24. Signature of other persons	
25. Signature of other persons		26. Signature of other persons		27. Signature of other persons		28. Signature of other persons	
29. Signature of other persons		30. Signature of other persons		31. Signature of other persons		32. Signature of other persons	
33. Signature of other persons		34. Signature of other persons		35. Signature of other persons		36. Signature of other persons	
37. Signature of other persons		38. Signature of other persons		39. Signature of other persons		40. Signature of other persons	
41. Signature of other persons		42. Signature of other persons		43. Signature of other persons		44. Signature of other persons	
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97. Signature of other persons		98. Signature of other persons		99. Signature of other persons		100. Signature of other persons	

RECEIVED BY JACOBUS ET AL. OCT 11 1904
BALTIMORE, MARYLAND

12038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY in 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Anne Central</u>				d. STREET ADDRESS <u>175 Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daisy</u> First <u>Murray</u> Middle Last				4. DATE OF DEATH <u>Nov</u> Month <u>21</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23/1913</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Arnold, A.A.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Maynard</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>219-28-614</u>		17. INFORMANT <u>Vernon Murray</u> Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Memor</u> <u>443X</u> DUE TO <u>Arterio-sclerotic Hy (arteriosclerotic) Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hy (arteriosclerotic) Cardiovascular Disease</u> DUE TO <u>Arterio-sclerotic Hy (arteriosclerotic) Cardiovascular Disease</u> (c) <u>Arterio-sclerotic Hy (arteriosclerotic) Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/19/58</u> 19 <u>58</u> , to <u>11/21/58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11/21/58</u> 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Roberts</u>				ADDRESS (Street, city or town, state) <u>110-CHURCH ST ANNAPOLIS MD</u>			
DATE SIGNED <u>11/21/58</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold A.A.C. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Johnson</u> ADDRESS <u>Annapolis, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12070

CERTIFICATE OF DEATH

12059

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. LENGTH OF STAY IN 1b <u>2/12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 25-A</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lance</u> Middle <u>Mason</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Sept 58</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dudley W. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Judith Maryann Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Dudley W. Myers</u>		Address <u>Box 25-a Jessup, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> <u>560.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthrogryposis</u> DUE TO (c) <u>Right Inguinal Hernia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 months</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>never</u>	
21. I certify that I attended the deceased from <u>16 Oct</u> , 19 <u>58</u> , to <u>16 Nov</u> , 19 <u>58</u> , that I <u>did</u> saw the deceased alive on <u>12</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. D.O.A. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Roger C Moyer</u>		M.D. <u></u>	
PHYSICIAN'S NAME (Type) <u>ROGER C. MOYER</u>		US Army Hospital, Fort George G. Meade, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Melton Van Horn Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Hellendale, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl B. Woberlon Funeral Home, Inc</u>		ADDRESS <u>6306 - Belair Rd. Baltimore - 6. Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

2

13070

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *WILLIAM J. HARRIS*

2. SEX: *Male*

3. AGE: *52*

4. DATE OF BIRTH: *1914*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *Electrician*

7. MARITAL STATUS: *Married*

8. DATE OF DEATH: *11/1/58*

9. PLACE OF DEATH: *Home*

10. CAUSE OF DEATH: *Myocardial Infarction*

11. MEDICAL HISTORY: *None*

12. SIGNATURE OF PHYSICIAN: *W. J. Harris*

13. SIGNATURE OF REGISTRAR: *W. J. Harris*

14. SIGNATURE OF WITNESSES: *W. J. Harris*

15. SIGNATURE OF DECEASED: *W. J. Harris*

16. SIGNATURE OF NEXT OF KIN: *W. J. Harris*

17. SIGNATURE OF BURIAL OFFICIAL: *W. J. Harris*

18. SIGNATURE OF FUNERAL HOME: *W. J. Harris*

19. SIGNATURE OF CHURCH: *W. J. Harris*

20. SIGNATURE OF OTHER: *W. J. Harris*

21. SIGNATURE OF OTHER: *W. J. Harris*

22. SIGNATURE OF OTHER: *W. J. Harris*

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99. SIGNATURE OF OTHER: *W. J. Harris*

100. SIGNATURE OF OTHER: *W. J. Harris*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12060

12071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>6m 8d</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1524 E. Preston Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mattina</u> Middle <u>Neal</u> Last <u>Neal</u>		4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>19 58</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Franklin (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Lucy (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and Dehydration</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of esophagus</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Schizophrenic Reaction, Paranoid Type</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/6</u> , 19 <u>58</u> , to <u>11/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>58</u> , and that death occurred at <u>1:10A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		M.D.		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>		DATE SIGNED <u>11/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville State Hospital, Md.</u>		<u>11/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Anne Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eloy O. Wilson</u>				ADDRESS <u>1000 Brantley Ave. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Munn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film 256 12-1-58 et

12072

CERTIFICATE OF DEATH

12061

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>16 X-2</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>Eymar Mobile Village, Gorman Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matthew G. Passick</u>		4. DATE OF DEATH Month Day Year <u>23 November 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>19 November 58</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Passick</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Ann Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>U.S. Army Hospital, Ft Meade, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> <u>prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19</u> , 19 <u>58</u> , to <u>Nov 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>58</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hosp, Ft Meade, Md</u> <u>23 Nov 58</u>			
ACTUAL SIGNATURE <u>James Glenn, Capt, MC</u>		M.D. <u>U.S. Army Hosp, Ft Meade, Md</u>	
PHYSICIAN'S NAME (Type) <u>JAMES GLENN, Capt, MC</u>		<u>U.S. Army Hospital, Ft Meade, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>11-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eaton Rapids Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eaton Rapids, Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 127 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

2050212XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12073

CERTIFICATE OF DEATH

12062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>21 y.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marley Park, Marley Neck Rd. and 11 Ave.</u>		d. STREET ADDRESS <u>Same</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Theodore Pfeifer</u>		4. DATE OF DEATH Month Day Year <u>November 28th. 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/81</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Pfeifer</u>		14. MOTHER'S MAIDEN NAME <u>Louise Gezell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-3081</u>	
17. INFORMANT <u>Mrs. Lillian B. Pfeifer (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Nov. 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28/58</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Glen Burnie, Md.</u> <u>11/28/58</u> ACTUAL SIGNATURE <u>Gustave H. Pfeifer, M.D.</u> M.D. PHYSICIAN'S NAME (Type) <u>Gustave H. Pfeifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 2-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd Balti Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G Zink</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
ADDRESS <u>Glen Burnie Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1991

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12074

CERTIFICATE OF DEATH

13279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>4y 1m 7d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u> <u>08X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucretia</u> Middle <u>Butler</u> Last <u>Proctor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884?</u>	9. AGE (In years last birthday) yrs. <u>74?</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benny Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Lee Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19- _____		20d. INJURY OCCURRED While _____ at work _____ Not while _____ at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10/21</u> , 19 <u>54</u> , to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>58</u> , and that death occurred at <u>10:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>11/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				ADDRESS <u>Crownsville State Hospital, Md.</u> <u>11/28/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Newport</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home, Waldorf Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

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1 7 M 10 I 0 VS A15 (4) 15M 10/57 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12075 CERTIFICATE OF DEATH

12063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2yrs. 6days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Arnolds P. O., Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bertha		Middle Griffin		Last Pulley		4. DATE OF DEATH Month 11 Day 13 Year 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1885		9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR Months 73	11. IF UNDER 24 HRS. Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Griffin				14. MOTHER'S MAIDEN NAME Mary Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a.) Cerebral Thrombosis DUE TO Generalized and Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b.) DUE TO (c.)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, Dehydration and Inanition - Glaucoma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour o. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/7 , 19 56 , to 11/13 , 19 58 , that I last saw the deceased alive on 11/13 , 19 58 , and that death occurred at 6:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 11/13/58							
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville State Hospital, Md.		DATE SIGNED 11/13/58		PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 11-16-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Arnolds, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese - Annapolis, Md.				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

1917

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		HOSPITAL	
CERTIFICATE OF DEATH		MAY BE OBTAINED FROM		FEE		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

12039

CERTIFICATE OF DEATH

Reg. Dist. No. 12064

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>F</u> Last <u>PUMPHREY</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>January 22, 1880</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>well digging</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Walter Pumphrey</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown Medford</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mr. Walter Pumphrey- Son; same ad # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease & Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>August 15, 1958</u> to <u>November 28, 1958</u> , that I last saw the deceased alive on <u>Nov. 28, 1958</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Ave.</u>		DATE SIGNED <u>11/30/58</u>			
PHYSICIAN'S NAME (Type) <u>Maurice F. Klawans MD</u>		ADDRESS <u>31 Southgate Ave. Annapolis, Md.</u>		22a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING AND KIRKLEY</u>				ADDRESS <u>Funeral Home Glen Burnie, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

CERTIFICATE OF DEATH

12065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Adams County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adams</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Samtulls Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Samtulls Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waucho Chapel Rd</u>				d. STREET ADDRESS <u>Waucho Chapel Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Queen</u> Last <u>Queen</u>				4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-16-1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min. <u>05</u>		IF UNDER 24 HRS. Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min. <u>05</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Georganna Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. (If yes, give war or date of service) <input type="checkbox"/>		17. INFORMANT <u>Georganna Hebron Samtulls Md</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO (c) <u>Malignancy (hepato sarcoma) Stomach</u> INTERVAL BETWEEN ONSET AND DEATH <u>33 hrs</u> <u>4 weeks</u> <u>8 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 25</u> , 19 <u>58</u> , to <u>Nov. 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>58</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton T. Waite</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md</u> DATE SIGNED <u>11-22-58</u>			
PHYSICIAN'S NAME (Type) <u>Merton T. Waite, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-27-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sebor</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Beesett</u> ADDRESS <u>108 N. St. Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12077

CERTIFICATE OF DEATH

Reg. Dist. No.

12066

1. PLACE OF DEATH a. COUNTY <u>ARUNDEL</u> CO. <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 months & 7 days 10 9 4 4 9 0 1 5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JANNS Nursing Home</u>		d. STREET ADDRESS <u>1495 Silompiro Rd -</u>	
3. NAME OF DECEASED (Type or print) <u>Mariano</u> First Middle Last		4. DATE OF DEATH <u>November 13</u> Month Day Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Filipino</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Philippine Islands -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. -</u>	
13. FATHER'S NAME <u>Daniel Rosette</u>		14. MOTHER'S MAIDEN NAME <u>Unknown -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes U.S. Navy 1945-1945</u>		16. SOCIAL SECURITY NO. <u>4-3-5-10495</u>	
17. INFORMANT <u>Mrs. Anna Spitto</u> Address <u>495 Silompiro Rd -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>H.S.A.V.D to Cardiac Failure -</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p) <u>Left Hemiplegia occasional Fibrillation (Atrial)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5 1958</u> to <u>November 13 1958</u> , that I last saw the deceased alive on <u>October 4 1958</u> , and that death occurred at <u>1:30 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Freckler</u> M.D. <u>10611 St. (P.O. Box 37) Odenton</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov -13-1958</u>	
PHYSICIAN'S NAME (Type) <u>Febru G. Gaunberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BaltoNat Cem. Balto. Md</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>2601 E. Madison St.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

Reg. Dist. No.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal - Burial	11-9-58	Gastonia Memorial Park	Gaston County, Gastonia, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE	/ ADDRESS		24a. REC'D BY REGISTRAR
HOPPING FUNERAL HOME	Annapolis, Maryland		DATE NOV 12 '58
			24b. REGISTRAR'S SIGNATURE
			Arthur L. Hance

VS A15 (4)
15M 9/55

2063274XV1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]		DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
DECEASED'S ADDRESS [Address]		DECEASED'S OCCUPATION [Occupation]		DECEASED'S MARITAL STATUS [Married/Single/etc.]		DECEASED'S RACE [Race]		DECEASED'S RELIGION [Religion]	
DECEASED'S SOCIAL SECURITY NUMBER [Number]		DECEASED'S MOTHER'S MARRIAGE LICENSE NUMBER [Number]		DECEASED'S MOTHER'S BIRTH DATE [Date]		DECEASED'S MOTHER'S BIRTH PLACE [Place]		DECEASED'S MOTHER'S RACE [Race]	
DECEASED'S FATHER'S MARRIAGE LICENSE NUMBER [Number]		DECEASED'S FATHER'S BIRTH DATE [Date]		DECEASED'S FATHER'S BIRTH PLACE [Place]		DECEASED'S FATHER'S RACE [Race]		DECEASED'S FATHER'S RELIGION [Religion]	
DECEASED'S DEATH DATE [Date]		DECEASED'S DEATH TIME [Time]		DECEASED'S DEATH PLACE [Place]		DECEASED'S DEATH CAUSE [Cause]		DECEASED'S DEATH MANNER [Manner]	
DECEASED'S DEATH CERTIFICATE NUMBER [Number]		DECEASED'S DEATH CERTIFICATE DATE [Date]		DECEASED'S DEATH CERTIFICATE PLACE [Place]		DECEASED'S DEATH CERTIFICATE RACE [Race]		DECEASED'S DEATH CERTIFICATE RELIGION [Religion]	
DECEASED'S DEATH CERTIFICATE SIGNATURE [Signature]		DECEASED'S DEATH CERTIFICATE SEAL [Seal]		DECEASED'S DEATH CERTIFICATE VERIFICATION [Verification]		DECEASED'S DEATH CERTIFICATE REVIEW [Review]		DECEASED'S DEATH CERTIFICATE APPROVAL [Approval]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Weems Creek RFD Annapolis,</u>	
		d. STREET ADDRESS <u>/</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT ALBERT SEARS</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>12</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1949</u>
9. AGE (In years last birthday) <u>9</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>3rd grade</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell Sears</u>		14. MOTHER'S MAIDEN NAME <u>Peggy Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Russell Sears- Father- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple injuries</u> 8/2x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto - Route 50</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11-12</u> p. m. <u>19 58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>HARPS MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>		DATE SIGNED <u>11-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaul</u>	

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12042 CERTIFICATE OF DEATH

12069

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>ANNAPOLIS</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>			
TOWN <u>ANNAPOLIS</u>				TOWN <u>Chesapeake</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL GEN. Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ADA</u> <u>SHIPLEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 1</u> 19 <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED, (Specify)	8. DATE OF BIRTH <u>AUG-25, 1895</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL CROUSE</u>				14. MOTHER'S MAIDEN NAME <u>EMMA GIBBLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Clarence Wagner, Chesapeake</u>			
(Yes, no, or unk.)		(If Yes, give war or dates of service)					
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
591X IMMEDIATE CAUSE (A) <u>UREMIA.</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>CHRONIC NEPHROSIS</u>							
STATING UNDERLYING CAUSE LAST, (C) <u>360X</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24</u> , 19 <u>54</u> , to <u>Nov-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bryant L. Jones</u>				ADDRESS (Street, city, town, state) <u>Chesapeake Md</u>		DATE SIGNED <u>11/3/58</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 4, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) <u>Denton, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Anthony S. Hackett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Jones</u>		ADDRESS <u>Denton</u>	
DATE <u>NOV 7 '58</u>							

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. 1900 CERTIFICATE OF DEATH

REG. DIST. NO.

IF DEATH OCCURRED IN THE CITY OF BALTIMORE

PLACE IN BLOCK

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 DATE OF DEATH

EDUCATION
 MARRIAGE
 PREVIOUS ILLNESS
 PREVIOUS SURGERY
 PREVIOUS TRAUMA
 PREVIOUS ACCIDENT

PREVIOUS DISEASE
 PREVIOUS INJURY
 PREVIOUS SURGERY
 PREVIOUS TRAUMA
 PREVIOUS ACCIDENT

PREVIOUS DISEASE
 PREVIOUS INJURY
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 PREVIOUS ACCIDENT

PREVIOUS DISEASE
 PREVIOUS INJURY
 PREVIOUS SURGERY
 PREVIOUS TRAUMA
 PREVIOUS ACCIDENT

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MD.
 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12078

CERTIFICATE OF DEATH

12070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>B. H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>18</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Caroline</u> First <u>Siegmund</u> Middle Last		4. DATE OF DEATH <u>November 13</u> 19 <u>58</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17/1869</u> 89 yrs.
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lohr</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Spath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Katherine Slater Jessup</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio. Vas. Disease</u> DUE TO (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 13, 1958</u> to <u>Nov. 13, 1958</u> that I last saw the deceased alive on <u>Nov. 13, 1958</u> and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>11/16/58</u>	
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Vernon Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Re Will Caralton</u> ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1958</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

CERTIFICATE OF DEATH

WIM BROMID

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12080

CERTIFICATE OF DEATH

Reg. Dist. No.

12072

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena PFD (Green Haven)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena PFD (Green Haven)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10th & Catherine Sts.</u>		d. STREET ADDRESS <u>10th & Catherine Sts.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Edith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Robert A. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Carbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Landon Smith</u>		18. ADDRESS <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 coronary occlusion</u> DUE TO (b) <u>hypertensive cardio-vascular disease</u> DUE TO (c) <u>lying cause lost.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1951</u> , to <u>Nov. 7, 1958</u> , that I last saw the deceased alive on <u>Nov. 7, 1958</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Phylis W. Keister, M.D.</u>		DATE SIGNED <u>11/8/58</u>	
PHYSICIAN'S NAME (Type) <u>P. W. KEISTER</u>		ADDRESS (Street, city or town, state) <u>302 Patuxent Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemo</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn PFD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. Singleton</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krasner</u>		24c. ADDRESS <u>Glen Burnie, Md.</u>	

02051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12073

12081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>Carr</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1905</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>53</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>603X</u> IMMEDIATE CAUSE (a) <u>Uremia and Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration, Malnutrition</u> DUE TO (c) <u>Renal Sufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>122X Syphilis with aneurism of the aorta and Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour <u>0</u> a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <u>11/5</u> , 19 <u>58</u> , to <u>11/24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>58</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>11/24/58</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u> M.D. <u>Crownsville State Hospital, Md.</u> 11/24/58 PHYSICIAN'S NAME (Type) <u>Crownsville State Hospital, Md.</u> 11/24/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. O. Wilson</u>				ADDRESS <u>1000 Blandy Ave.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 1958</u>	
24b. REGISTRAR'S SIGNATURE							

12082

CERTIFICATE OF DEATH

12074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE-ARUNDEL MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. LENGTH OF STAY IN 1b <u>17 years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>				d. STREET ADDRESS <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JUMPER-HOLE-RL.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES-BERTAUDE-SWELLING</u>				4. DATE OF DEATH Month Day Year <u>Nov. 14</u> 19 <u>58</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/66</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mail carrier own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE-MD</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Lewis</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mrs. Charles E. PETETT</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>over 5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/13/53</u> , 19 <u>53</u> , to <u>11/14/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/1/58</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eustace H. Faubert, M.D.</u>				ADDRESS (Street, city or town, state) <u>5-First Ave. S.E.</u>			
PHYSICIAN'S NAME (Type) <u>EUSTACE H. FAUBERT - M.D.</u>				DATE SIGNED <u>11/14/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>William E. Kraw</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 28 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12083

CERTIFICATE OF DEATH

12075

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital, Ft Geo G. Meade, Md			d. STREET ADDRESS 3 Mulberry Rd, Timber Ridge		
3. NAME OF DECEASED (Type or print) First Alexander Middle Michael Last Staniec			4. DATE OF DEATH Month November Day 8 Year 19 58		
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Jan 1920	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Syracuse, New York
13. FATHER'S NAME Alexander Michael Staniec			14. MOTHER'S MAIDEN NAME Victoria (last name unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) From Sep 1939			16. SOCIAL SECURITY NO. 067-18-9978		
17. INFORMANT Military Personnel Officer, Ft Geo G Meade, Md			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe coronary arteriosclerosis with partial occlusion of left anterior descending coronary artery, with complete occlusion of the right coronary artery by arteriosclerotic plaques. Acute pulmonary congestion and edema. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from Dead on Arrival , to _____, 19_____, that I last saw the deceased 3:30 PM DOA , 19_____, and that death occurred at _____, from the causes and on the date stated above. 5:23 PM ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE Sol Colsky			M.D. _____		
PHYSICIAN'S NAME (Type) SOL COLSKY, Captain, MC			Fort George G. Meade, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-13-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
22d. LOCATION (City, town, or county) Kansas City, Kansas		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street			ADDRESS _____		
24a. REC'D BY REGISTRAR NOV 13 '58			24b. REGISTRAR'S SIGNATURE C. L. H. H. H.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>10m 5d</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1805 Thomas Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H</u> Last <u>Stevenson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1939</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Stevenson, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Louise</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>353.3</u> IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epileptic Seizure</u> DUE TO (c) <u>Major Epilepsy</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had epileptic seizure & fell face down in water</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:13</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Residential</u>		20f. (City or town) <u>Baltimore</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-17-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN STAR</u>		22d. LOCATION (City, town, or county) (State) <u>CATONVILLE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin A. Williams</u> ADDRESS <u>1805 N. Monroe St.</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 17 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. SMITH		2. PLACE OF DEATH BALTIMORE, MARYLAND	
3. DATE OF DEATH JANUARY 15, 1918		4. TIME OF DEATH 10:30 A.M.	
5. SEX Male		6. AGE 45 Years	
7. OCCUPATION Carpenter		8. MARITAL STATUS Married	
9. PLACE OF BIRTH BALTIMORE, MARYLAND		10. COLOR White	
11. EDUCATION High School		12. RELIGION Roman Catholic	
13. PRESENT ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MARYLAND		14. USUAL RESIDENCE Same as present address	
15. CAUSE OF DEATH Heart Disease		16. MANNER OF DEATH Natural	
17. SIGNATURE OF EXAMINER J. H. SMITH		18. SIGNATURE OF WITNESSES J. H. SMITH	
19. SIGNATURE OF DECEASED J. H. SMITH		20. SIGNATURE OF NEAREST RELATIVE J. H. SMITH	
21. SIGNATURE OF CLERK J. H. SMITH		22. SIGNATURE OF JURY J. H. SMITH	
23. SIGNATURE OF JURY J. H. SMITH		24. SIGNATURE OF JURY J. H. SMITH	
25. SIGNATURE OF JURY J. H. SMITH		26. SIGNATURE OF JURY J. H. SMITH	
27. SIGNATURE OF JURY J. H. SMITH		28. SIGNATURE OF JURY J. H. SMITH	
29. SIGNATURE OF JURY J. H. SMITH		30. SIGNATURE OF JURY J. H. SMITH	
31. SIGNATURE OF JURY J. H. SMITH		32. SIGNATURE OF JURY J. H. SMITH	
33. SIGNATURE OF JURY J. H. SMITH		34. SIGNATURE OF JURY J. H. SMITH	
35. SIGNATURE OF JURY J. H. SMITH		36. SIGNATURE OF JURY J. H. SMITH	
37. SIGNATURE OF JURY J. H. SMITH		38. SIGNATURE OF JURY J. H. SMITH	
39. SIGNATURE OF JURY J. H. SMITH		40. SIGNATURE OF JURY J. H. SMITH	
41. SIGNATURE OF JURY J. H. SMITH		42. SIGNATURE OF JURY J. H. SMITH	
43. SIGNATURE OF JURY J. H. SMITH		44. SIGNATURE OF JURY J. H. SMITH	
45. SIGNATURE OF JURY J. H. SMITH		46. SIGNATURE OF JURY J. H. SMITH	
47. SIGNATURE OF JURY J. H. SMITH		48. SIGNATURE OF JURY J. H. SMITH	
49. SIGNATURE OF JURY J. H. SMITH		50. SIGNATURE OF JURY J. H. SMITH	
51. SIGNATURE OF JURY J. H. SMITH		52. SIGNATURE OF JURY J. H. SMITH	
53. SIGNATURE OF JURY J. H. SMITH		54. SIGNATURE OF JURY J. H. SMITH	
55. SIGNATURE OF JURY J. H. SMITH		56. SIGNATURE OF JURY J. H. SMITH	
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59. SIGNATURE OF JURY J. H. SMITH		60. SIGNATURE OF JURY J. H. SMITH	
61. SIGNATURE OF JURY J. H. SMITH		62. SIGNATURE OF JURY J. H. SMITH	
63. SIGNATURE OF JURY J. H. SMITH		64. SIGNATURE OF JURY J. H. SMITH	
65. SIGNATURE OF JURY J. H. SMITH		66. SIGNATURE OF JURY J. H. SMITH	
67. SIGNATURE OF JURY J. H. SMITH		68. SIGNATURE OF JURY J. H. SMITH	
69. SIGNATURE OF JURY J. H. SMITH		70. SIGNATURE OF JURY J. H. SMITH	
71. SIGNATURE OF JURY J. H. SMITH		72. SIGNATURE OF JURY J. H. SMITH	
73. SIGNATURE OF JURY J. H. SMITH		74. SIGNATURE OF JURY J. H. SMITH	
75. SIGNATURE OF JURY J. H. SMITH		76. SIGNATURE OF JURY J. H. SMITH	
77. SIGNATURE OF JURY J. H. SMITH		78. SIGNATURE OF JURY J. H. SMITH	
79. SIGNATURE OF JURY J. H. SMITH		80. SIGNATURE OF JURY J. H. SMITH	
81. SIGNATURE OF JURY J. H. SMITH		82. SIGNATURE OF JURY J. H. SMITH	
83. SIGNATURE OF JURY J. H. SMITH		84. SIGNATURE OF JURY J. H. SMITH	
85. SIGNATURE OF JURY J. H. SMITH		86. SIGNATURE OF JURY J. H. SMITH	
87. SIGNATURE OF JURY J. H. SMITH		88. SIGNATURE OF JURY J. H. SMITH	
89. SIGNATURE OF JURY J. H. SMITH		90. SIGNATURE OF JURY J. H. SMITH	
91. SIGNATURE OF JURY J. H. SMITH		92. SIGNATURE OF JURY J. H. SMITH	
93. SIGNATURE OF JURY J. H. SMITH		94. SIGNATURE OF JURY J. H. SMITH	
95. SIGNATURE OF JURY J. H. SMITH		96. SIGNATURE OF JURY J. H. SMITH	
97. SIGNATURE OF JURY J. H. SMITH		98. SIGNATURE OF JURY J. H. SMITH	
99. SIGNATURE OF JURY J. H. SMITH		100. SIGNATURE OF JURY J. H. SMITH	

12043

CERTIFICATE OF DEATH

12077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>W. D. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Adm</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. D. Genl Hosp</u>		d. STREET ADDRESS <u>410 Seaborn Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Carroll Stimar</u>		4. DATE OF DEATH <u>2001-15-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/1900</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic - Auto Trucks</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Stimar</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-4593</u>	
17. INFORMANT <u>Mr. Grace W. Stimar - Annapolis</u>		Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>PULMONARY FIBROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 mos</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COMPENSATORY POLYCYTHEMIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>53</u> , to <u>15 NOV</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 NOV</u> , 19 <u>58</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Beck</u>		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>11/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	22b. DATE THEREOF <u>2001-18/18</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Brown Co - 108 W. 4th St.</u>		ADDRESS <u>Annapolis, Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12085

CERTIFICATE OF DEATH

12079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne A rundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Oak Lane NW		d. STREET ADDRESS 201 Oak Lane NW	
3. NAME OF DECEASED (Type or print) First Harriet Middle Lavina Last Thompson		4. DATE OF DEATH Month 11 Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Phylitas Weber	
14. MOTHER'S MAIDEN NAME (Unk.)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 218-28-8375		17. INFORMANT Rex L. Thompson, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Hypertensive Cardio- 260x DUE TO Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 7 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 51 , to 11-15 , 19 58 , that I last saw the deceased alive on 11-15 , 19 58 , and that death occurred at 7:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. R. MacDonald M.D.		DATE SIGNED 11-15-58	
PHYSICIAN'S NAME (Type) C. R. MacDonald,		204 Crain Highway SW, Glen Burnie	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/58	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Ma.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		24a. REC'D BY REGISTRAR Nov 18 '58	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12080

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La urel Race Track		c. LENGTH OF STAY IN lb 2 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grandstand - Laure l Racetrack		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
f. STREET ADDRESS 1215 Gates Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Van Os Last		4. DATE OF DEATH Month Nov. Day 11, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dealer		10b. KIND OF BUSINESS OR INDUSTRY Livestock	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Van Os		14. MOTHER'S MAIDEN NAME Rosa Schloss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0-0-0-0-0-0-0-0-0-0	
17. INFORMANT Mrs Eloise Lowenberg Van Os, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11/11 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Race Track	20f. (City or town) Laurel
20g. (County) AA		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		DATE SIGNED Nov. 11, 1958	
EXAMINER'S NAME (Type) Gustave H. Faubert, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/13/58	22c. NAME OF CEMETERY OR CREMATORY Forest Lawn	22d. LOCATION (City, town, or county) Norfolk, Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Hopping</i>		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanning</i>		24c. ADDRESS Hopping and Kirkley, Glen Burnie, Md.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

15080

John J. Jones

John J. Jones - 2100

John J. Jones - 2100

John J. Jones

John J. Jones

John J. Jones

John J. Jones

NO

John J. Jones

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John J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12087

CERTIFICATE OF DEATH

12081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A A Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A A Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale md</u>		c. LENGTH OF STAY IN 1b <u>X Deale md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ISABELL</u> First <u>WARD</u> Middle Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18, 1884</u>
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Friendship, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Atwell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dove</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LeRoy WARD Deale, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis, coma</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO (c) <u>Severe hypertrophic arthritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>ad</u> , 19 <u>55</u> , to <u>Nov 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		ADDRESS (Street, city or town, state) <u>Sethman md</u> DATE SIGNED <u>11-11-58</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Friendship, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Hardisty</u>		ADDRESS <u>Galesville Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

F30SE

12044

CERTIFICATE OF DEATH

12082

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				d. STREET ADDRESS 1 810 Chesapeake Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY S WARTHEN				4. DATE OF DEATH Month Day Year NOVEMBER 11 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1879		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Warthen				14. MOTHER'S MAIDEN NAME Anna DeLauder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address 215-28-0335 A Mr Arthur S. Warthen- Son- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia L.A.L. 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. septicemic & purulent pleurisy DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic heart & bronchial asthma							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-10-58 , to 11-11-58 , that I last saw the deceased alive on 11-11-58 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Frank M Shipley M.D. 1210 Catheons Rd 11-14-58							
ACTUAL SIGNATURE Frank M Shipley				PHYSICIAN'S NAME (Type) Frank Shipley MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES A. JONES		JAN 15 1968	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL	
MD		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. A. JONES		J. A. JONES	
DATE		DATE	
JAN 15 1968		JAN 15 1968	

RECEIVED

12083

12088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 28y 10m 9d			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			d. STREET ADDRESS Unknown			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William			Middle Washington			Last Washington			4. DATE OF DEATH Month 11		
5. SEX Male			6. COLOR OR RACE Negro			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1885?		
9. AGE (In years lost birthday) 73? yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Washington			14. MOTHER'S MAIDEN NAME Harriet Washington								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the prostate, inoperable with metastases DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis with Cardiac Decompensation, Myocardial Infarct and Decubital Ulcers									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1/13 1930 to 11/22 1958, that I last saw the deceased alive on 11/22 1958, and that death occurred at 1:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital 11/24/58 M. D.											
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.			PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			Crownsville State Hospital			11/24/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-25-1958			22c. NAME OF CEMETERY OR CREMATORY V. and W. School			22d. LOCATION (City, town, or county) (State) Baltimore Md		
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Reese #188 Wash St. Baltimore			ADDRESS			24a. REC'D BY REGISTRAR DATE NOV 28 '58			24b. REGISTRAR'S SIGNATURE Arthur S. Fraser		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PAUL M. BROWN
RACIAL
MASSACHUSETTS

Name of Deceased		Paul M. Brown	
Sex		Male	
Age		35	
Date of Birth		1915	
Place of Birth		Boston, Mass.	
Usual Residence		Boston, Mass.	
Cause of Death		Heart Disease	
Date of Death		1950	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Burial Place		Cemetery	
Burial Date		1950	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12089

CERTIFICATE OF DEATH

12084

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden on the Severn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden on the Severn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NANCY Lane</u>				d. STREET ADDRESS <u>Nancy Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Eugene</u> Last <u>Weedon</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 Feb. 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 2 YEARS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William M. Weedon</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Woodward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-2930</u>		17. INFORMANT <u>wife Mrs Weedon</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Ca of Colon</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>1958</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11-5-58</u> , 19 <u> </u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Robert R. Hahn</u>				ADDRESS (Street, city or town, state) <u>Severna Park Md 21-688</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>				DATE SIGNED <u>11-5-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Co. Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Inc. 1328 Sulphur Spring Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

12384

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

12384

11/10

Name of Deceased		Date of Death	
Sex		Age	
Race		Marital Status	
Occupation		Cause of Death	
Place of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12093

12048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>D. D. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D. D. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Central Street</u>				d. STREET ADDRESS <u>912 Central Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wynn</u> Last <u></u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-6-1885</u>	
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Adams Bluff Cem.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham Wynn</u>				14. MOTHER'S MARRIED NAME <u>Francis Blueberry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Myrtle Wynn</u>				Address <u>912 Central St. Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive cardiac failure</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month <u></u> Day <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-4-58</u> 19 <u></u> , to <u>11-23-58</u> 19 <u></u> , that I last saw the deceased alive on <u>11-22-58</u> 19 <u></u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>62 Cathedral St</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				DATE SIGNED <u>11-24-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-26-1958</u>		<u>Brewer Hall</u>		<u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>			
ADDRESS <u></u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

12045

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen'l Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severn Park (Hollywood on the Severn)</u>	
		f. STREET ADDRESS <u>Holly Rd. Rt. 2- Box. 458</u>	
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Bagley</u> Last <u>Wenrich</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14- 1939</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elton T. Wenrich</u>		14. MOTHER'S MAIDEN NAME <u>Ruth G. Bagley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Act. Res. USA Unknown</u>	
17. INFORMANT <u>Mr. Elton T. Wenrich</u>		Address <u>Same as no #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>823X</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Riding in auto, which struck a tree.</u>	
20c. TIME OF INJURY Hour <u>1:30 P.m.</u> Month, Day, Year <u>11/23/1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Earleigh Rd. Severn Park, A. Arundel</u>		20f. (City or town) (County) (State) <u>Severn Park, Anne Arundel, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
		DATE <u>NOV 28 '58</u>	

FOR STATE
HEALTH DEPT

DATE OF BIRTH
1911

DATE OF DEATH
1911

SEX
MALE

+

1911

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 11 1911
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12046

CERTIFICATE OF DEATH

12086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Annapolis, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>Tracy's Landing</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>WILKERSON</u>				4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 November 1958</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles Gordon WILKERSON</u>				14. MOTHER'S MAIDEN NAME <u>Annette SIMMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>6 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9 November</u> , 19 <u>58</u> , to <u>14 November</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 November</u> , 19 <u>58</u> , and that death occurred at <u>9:14 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>11-15-58</u>							
ACTUAL SIGNATURE <u>F. M. KENNY</u> M.D.							
PHYSICIAN'S NAME (Type) <u>F. M. KENNY, LT, MC, USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery Annapolis Md.</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. (Annapolis) Md.</u>				ADDRESS <u>108 Wash. St. (Annapolis) Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12090

CERTIFICATE OF DEATH

12087

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville - md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sara Murray Home</u>		d. STREET ADDRESS <u>Millersville Md</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline G. Williams</u> First Middle Last		4. DATE OF DEATH <u>11-16-</u> Month Day Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-14-1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (School)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. William - G - Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda - Linthicum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MARY V - SADA</u> Address <u>CECIL RD - MILLERSVILLE - MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Acute Lobar Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Enterovirus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u> <u>Urinary Incontinence</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 8 -</u> , 19 <u>58</u> , to <u>Nov 16 -</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 16 - 58</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKEY</u> M.D.		ADDRESS (Street, city or town, state) <u>Odenton Md</u> DATE SIGNED <u>11-16-58</u>	
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St STEPHENS</u>		22d. LOCATION (City, town, or county) (State) <u>MILLERSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weller Sr</u> ADDRESS <u>Baltimore Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12088

Reg. Dist. No.

12091

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potapsco Park</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hoffman Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Williams</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6th.</u> Year <u>19 58</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bowie, Prince George Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Giles</u>	
14. MOTHER'S MAIDEN NAME <u>Sallie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Sarah Hammond, (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/6/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>				ADDRESS <u>322 N. Schroeder St.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13088

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13081

THE STATE
HEALTH DEPT

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12092

CERTIFICATE OF DEATH

12089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md.</u>		c. LENGTH OF STAY IN 1b <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1, Box 173 B9 Loch Haven</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Raymond</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>10</u> - Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1988</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>	11. BIRTH PLACE (State or foreign country) <u>NEW YORK</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INVESTMENT</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>"UAK"</u>		14. MOTHER'S MAIDEN NAME <u>"UAK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UWT</u>	
17. INFORMANT <u>Mrs. Elva Charlotte</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Angina pectoris</u> DUE TO (c) <u>Hypertensive cardio-vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 weeks</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus for 9 years</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>58</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.		DATE SIGNED <u>RTD #1 Box 277 - M 11-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim, M.D. Edgewater, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arkington NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>Arkington VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12093

Reg. Dist. No.

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> .. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN lb <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>407 Hawthorne Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Horace Randall Wilson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>26th</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/91</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman for Gas & Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highland, Howard Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1918 (2 months)</u>		16. SOCIAL SECURITY NO. <u>212-05-7125</u>		17. INFORMANT Address <u>Mrs. Emma Wilson, (Wife) 407 Hawthorne Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Howard Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir. 4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

MEDICAL CERTIFICATION

1504

CONCLUSION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12094

CERTIFICATE OF DEATH

12091

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Crownsville, Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	c. LENGTH OF STAY IN 1b <u>11 yrs 6 mos</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> <u>17x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>NONE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Spencer</u> Last <u>Winchester</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Harrison Winchester</u>	
14. MOTHER'S MAIDEN NAME <u>Molema Rochester</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harrison Winchester</u> Address <u>Barclay, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden death, cause unknown</u> <u>420.1</u> DUE TO <u>probably due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with meningoencephalitic central nervous system syphilis (general paresis)</u> <u>025X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/23</u> , 19 <u>47</u> to <u>11/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>58</u> , and that death occurred at <u>11:30A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lindsey D. Campbell</u>		DATE SIGNED <u>11-9-58</u>	
PHYSICIAN'S NAME (Type) <u>Lindsey D. Campbell, M.D.</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Barclay</u>		22d. LOCATION (City, town, or county) (State) <u>Greenwood Barclay, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond B. Rawlings</u>		ADDRESS <u>Greenwood Barclay</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,8,9 FilmG237 1-12-59 et
12047
CERTIFICATE OF DEATH

12092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"At home"</u>		d. STREET ADDRESS <u>729 Rosedale St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CELESTINA Louise Wood</u>		4. DATE OF DEATH Month Day Year <u>Nov. 3 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1877</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jos. A. Arth</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Seale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Evelyn Wood</u>		Address <u>729 Rosedale St Annapolis Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY/ARTER/ DISEASE</u> DUE TO (c) <u>10 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>54</u> , to <u>3 NOV</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 NOV</u> , 19 <u>58</u> , and that death occurred at <u>7:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward L Beck</u>		ADDRESS (Street, city or town, state) <u>415 Southgate Ave Annapolis</u>	
DATE <u>11/4/58</u>		DATE SIGNED <u>11/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward L Beck</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>11/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard J. Selville</u>		ADDRESS <u>used</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1908

Page No. 10

NAME OF DECEASED <i>WILLIAM WOOD</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Aug 10 1908</i>		PLACE OF DEATH <i>Home</i>	
BIRTH DATE <i>Mar 15 1863</i>		BIRTH PLACE <i>Woods</i>		MARRIAGE DATE <i>Nov 10 1885</i>		MARRIAGE PLACE <i>Woods</i>		OCCUPATION <i>Farmer</i>		CAUSE OF DEATH <i>Heart Disease</i>	
FATHER'S NAME <i>John Wood</i>		MOTHER'S NAME <i>Mary Wood</i>		FATHER'S OCCUPATION <i>Farmer</i>		MOTHER'S OCCUPATION <i>Housewife</i>		EDUCATION <i>Common School</i>		RELIGION <i>Methodist</i>	
PREVIOUS ILLNESS <i>None</i>		PREVIOUS SURGERY <i>None</i>		PREVIOUS TRAUMA <i>None</i>		PREVIOUS TOXICITY <i>None</i>		PREVIOUS INFECTION <i>None</i>		PREVIOUS OTHER <i>None</i>	
SIGNS AND SYMPTOMS <i>None</i>		TREATMENT <i>None</i>		DIAGNOSIS <i>Heart Disease</i>		PROGNOSIS <i>None</i>		PATHOLOGICAL FINDINGS <i>None</i>		MANNER OF DEATH <i>Natural</i>	
CERTIFICATE OF DEATH <i>None</i>		DEATH CERTIFICATE <i>None</i>		DEATH RECORD <i>None</i>		DEATH INDEX <i>None</i>		DEATH LIST <i>None</i>		DEATH SUMMARY <i>None</i>	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12095

CERTIFICATE OF DEATH

12094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last YOUNG		d. STREET ADDRESS Route-1 Box 343-M; Severna Park	
4. DATE OF DEATH Month November Day 26 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY In General	
11. BIRTHPLACE (State or foreign country) Cambridge; Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Young		14. MOTHER'S MAIDEN NAME Harriett Nickolson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-4505	
17. INFORMANT Clara Young		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.H.C.V.D DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sep. 7, 1958 , to Nov. 26, 1958 , that I last saw the deceased alive on Nov. 25, 1958 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 844 N. Carey, Baltimore, Md. DATE SIGNED ACTUAL SIGNATURE George McDonald M.D. PHYSICIAN'S NAME (Type) George Mc Donald M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Towneek; Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		ADDRESS 1000 Brantley Avenue	
24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE William L. Frank	

